Harvard Pilgrim Health Care

Massachusetts

The Harvard Pilgrim Primary Choice HMO

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2018 — 06/30/2019
Coverage for: Individual + Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.harvardpilgrim.org**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other **underlined** terms see the Glossary. You can view the Glossary at **www.harvardpilgrim.org/fhcr** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why this matters
What is the overall deductible?	$400 member / $800 family	Generally you must pay all the costs up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care**, **provider** office visits, mental health, **rehabilitation services**, and **habilitation services** are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But, a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	Yes. **Prescription Drug Deductible:** $100 member / $200 family There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out–of–pocket limit for this plan?	$5,000 member / $10,000 family	The **out-of-pocket limit** is the most you could pay in a year of covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limit** until family **out-of-pocket limit** has been met.

Important Questions	Answers	Why this matters
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx** or call **1-888-333-4742** for a list of **preferred providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance-billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes, some exceptions apply.	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a **referral** before you see the **specialist**.

Copayments and **coinsurance** cost shown in this chart are both before and after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 **copay**/ visit; **deductible** does not apply	Not covered	None
	Specialist visit	**Level 1:** $30 **copay**/ visit; **deductible** does not apply **Level 2:** $60 **copay**/ visit; **deductible** does not apply	Not covered	None
	Preventive care/**screening**/ **immunization**	No charge; **deductible** does not apply	Not covered	None
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 **copay**/ scan	Not covered	Participating Providers limited to a maximum of one **copay**/ Member/ day.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.express-scripts.com/gicrx**.	Generic drugs	**Retail:** $10 copay after deductible **Maintenance 90/Mail Order:** $25 copay after deductible		Prescription drug coverage is administered by Express Scripts. For additional information, visit **www.express-scripts.com/gicrx** or call Customer Service at **1-855-283-7679 (TTY 711)**. Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Preferred brand drugs	**Retail:** $30 copay after deductible **Maintenance 90/Mail Order:** $75 copay after deductible		
	Non-preferred brand drugs	**Retail:** $65 copay after deductible **Maintenance 90/Mail Order:** $165 copay after deductible		
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy		Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/ visit	Not covered	Up to four Surgical Day Care Copays/ member/ year.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$100 copay/ visit		None
	Emergency medical transportation	No charge		None
	Urgent care	**Convenience care clinic:** $10 copay/ visit; deductible does not apply **Urgent care clinic (including hospital urgent care clinic):** $20 copay/ visit; deductible does not apply	**Convenience care clinic:** $10 copay/ visit; deductible does not apply **Urgent care clinic (including hospital urgent care clinic):** $20 copay/ visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	**Tier 1:** $275 copay/ admit **Tier 2:** $500 copay/ admit	Not covered	Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter.
	Physician/surgeon fee	No charge	Not covered	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$20 copay/ visit; deductible does not apply	Not covered	None
	Inpatient services	$275 copay/ admit; deductible does not apply	Not covered	Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$20 copay/ visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Up to one Medical or Mental Health & Substance Abuse Hospital Inpatient Copay/ Member each Quarter.
	Childbirth/delivery facility services	**Tier 1:** $275 copay/ admit **Tier 2:** $500 copay/ admit	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	**Physical & Occupational Therapy:** $20 copay/ visit; deductible does not apply **Speech Therapy:** No charge; deductible does not apply	Not covered	Physical & Occupational Therapy – 90 consecutive days/ illness or injury
	Habilitation services	**Physical & Occupational Therapy:** $20 copay/ visit; deductible does not apply **Speech Therapy:** No charge; deductible does not apply	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	– 45 days/ year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	For inpatient services, see "If you have a hospital stay".
If your child needs dental or eye care	Children's eye exam	**Optometrist:** $20 copay/ visit; deductible does not apply **Ophthalmologists:** **Level 1:** $30 copay/ visit; deductible does not apply **Level 2:** $60 copay/ visit; deductible does not apply	Not covered	– 1 exam every 24 months
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Most Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Services that are not Medically Necessary
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic Care - 20 visits/ year
- Hearing Aids - $2,000/ hearing aid every 24 months/ impaired ear up to age 22
- Hearing Aids - up to $1,700 every 2 years for age 22 or older
- Infertility Treatment - 5 cycles advanced reproductive technology/ lifetime
- Routine eye care (Adult) - 1 exam every 24 months

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Does this plan provide Minimum Essential Coverage? Yes

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium** tax credit to help you pay for a **plan** through the **Marketplace**.

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助，请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost sharing amounts (deductible, copayment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	$500
■ **Specialist *copayment***	$30
■ **Hospital (facility) *copayment***	$275
■ **Other *copayment***	$0
This EXAMPLE event includes services like:	
Specialist office visits (*prenatal care*)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (*ultrasounds and blood work*)	
Specialist visit (*anesthesia*)	
Total Example Cost	**$12,731**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$780**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	$500
■ **Specialist *copayment***	$30
■ **Hospital (facility) *copayment***	$275
■ **Other *copayment***	$0
This EXAMPLE event includes services like:	
Primary care physician office visits (*including disease education*)	
Diagnostic tests (*blood work*)	
Prescription drugs	
Durable medical equipment (*glucose meter*)	
Total Example Cost	**$7,389**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$320
Copayments	$1,620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,970**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$500
■ **Specialist *copayment***	$30
■ **Hospital (facility) *copayment***	$275
■ **Other *copayment***	$0
This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies*)	
Diagnostic test (*x-ray*)	
Durable medical equipment (*crutches*)	
Rehabilitation services (*physical therapy*)	
Total Example Cost	**$1,925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُغة **العربية** ، خَدَمات اَلمُساعَدة اَللُغَوية مُتَوفرة لك مَجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសូជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

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한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

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HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.